STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155729	A. BUILDING 00 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE OF HERITAGE, THE	12011 WHITTERN RD MONROEVILLE, IN46773

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F0000	This visit was for investigation of Complaint Number IN00093942. Complaint Number IN00093942-Substantiated. Federal/state deficiencies related to the allegations are cited at F 223 and F 226. Survey dates: August 1, 2, 2011 Facility number: 002549 Provider number: 155729 Aim number: 200289420 Survey team: Ann Armey, RN TC Ellen Ruppel, RN Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 6 Medicaid: 34 Other: 19 Total: 59 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	8/15/11Ms. Kim Rhoades, Director of Long Term CareIndiana State Department of Health2 North Meridian StreetIndianapolis, IN 46204Dear Ms. Rhoades,Enclosed is The Village of Heritage's Plan of Correction for our complaint survey on August 2, 2011.The Village of Heritage is requesting paper compliance for F223, SS: D; and F226, SS:D.The attached plan of correction is our credible allegation of compliance.Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or an agreement by The Village of Heritage of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws.Sincerely,Stephanie D. Allen, HFAAdministrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0223 SS=D	Quality review completed 8/3/11 Cathy Emswiller RN The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review, the facility failed to assure a resident was free from sexual mistreatment by another resident (Resident #B) . This deficiency affected 1 of 1 residents, reviewed for sexual mistreatment in a sample of 4. (Resident #C) Findings include: During interview, on 8/1/11 at 1:45 P.M., the Administrator indicated, on 7/19/11, Resident #B was found in Resident #C's room with his head between her legs. According to the Administrator, hall cameras had recorded Resident #B's entrance into the room at 3:11 A.M. and his removal from the room, at 3:21 A.M. The Administrator indicated Resident #B had no prior sexual behaviors. She indicated, after the incident, Resident #B was placed on 15 minute checks, transferred to a behavior center, and had recently returned to the facility. The	F0223	1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B was sent to Behaviorial Health for evaluation. Residents B and C will be monitored weekly x 4 weeks and monthly x 6 months by Social Services. (Addendum A)2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A door alarm was place on Resident B's door. (Addendum B). All other residents in the facility were interviewed on 7/19/11 by the MDS coordinator and DON regarding any concerns with residents entering your room unwanted or having any trouble with other residents. There were no concerns voiced. (Addendum C) All residents residing in the facility are interviewed with a quarterly Abuse Prohibition Interview that is completed in accordance with the MDS schedule. (Addendum D)3. What measures will be put into	09/01/2011

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	Administrator indicated Resident #C was assessed and had no physical injuries. The incident was investigated and reported to the ISDH (Indiana State Department of Health). On 8/1/11 at 2:00 P.M., accompanied by LPN #1, Resident #B was observed in his room in bed. A motion alarm was on the door. During interview at that time, LPN #1 indicated the door alarm was turned on at 10:00 P.M. and would alert staff if Resident #B left his room during the night. The alarm was checked by LPN #1 and was working. On 8/1/11 at 2:30 P.M., the clinical record of resident #B was reviewed and indicated the resident was admitted to the facility on 11/17/10, with diagnoses which included but were not limited to, Alzheimer's disease, dementia and depression. The MDS (Minimum Data Set) assessment, dated 5/5/11, indicated the resident had severe cognitive impairment and was independent with transfer and ambulation. The resident was readmitted to the facility from the behavioral unit on 7/28/11. The clinical record of Resident #C was reviewed on 8/1/11 at 2:30 P.M. and indicated the resident was admitted to the		place or what systemic changes will be made to ensure that the deficient practice does not recur? Resident B is being followed by the facility behavior management doctor and by the MSW. (Addendum E) Resident B is on 15 minute checks throughout the day, and has a door alarm that is on at night, with function checked on night shift. (Addendum F) Resident B was started on Lexapro and Risperdal. (Addendum G)4. How will the corrective actions be monitored to ensure the deficient practice will not recur? Resident B and C will be monitored weekly x 4 weeks and monthly x 6 months by Social Services with results to QA. Abuse prohibition quarterly interview results will be monitored by the administrator or designee with results to QA x 6 months.5. In compliance by 9/1/11.	

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	facility on 3/1/10 with diagnoses which included but were not limited to Alzheimer's disease and psychosis. The MDS assessment, dated 4/14/11, indicated the resident had severe cognitive impairment and was independent with transfers and ambulation. On 8/1/11 at 3:20 P.M., Resident #C was interviewed. She indicated she had no fear of anyone, and no one had been inappropriate with her. The investigation of the incident was reviewed on 8/1/11 at 3:30 P.M. A statement from CNA #2, dated 7/19/11, indicated she was doing her rounds and heard noises like snoring so she turned on the light in Resident #C's room and saw someone bent over Resident #C. CNA #2 indicated she shut off the light to go get the nurse and then went back to Resident #C's room to double check what she had seen. "...When I turned on the light I then realized someone was doing a sexual action to (Resident #C's name). I went to get the nurse. (nurses name) I got the nurse & (and) told her someone was sexually attacking (Resident #C's name) & (and) when I turned on the light he didn't stop. The nurse & I went into (Resident #C's name) room & (and) grabbed (Resident #B's name) arm & (and) told him he had to stop & (and) go			

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	back to his room..." The statement indicated she had seen Resident #B in the hall earlier and he said he was going to the door to check the weather. LPN #3's statement indicated CNA #2 came and got her and they went to Resident #C's room and found Resident #B's head between Resident #C's legs in her pubic area. Resident #B was "licking or sucking or kissing that area. She was lying there very still..." The statement further indicated, after Resident #B was taken to his room, she the CNA went back to check on Resident #C. "...She said she was okay, grabbed our hands et (and) said 'thank you' several times..." On 8/1/11 at 4:30 P.M., the Administrator was interviewed regarding why the aide had not immediately intervened to protect Resident #C. The Administrator indicated she had noted the CNA did not intervene immediately and all staff had been inserviced following the incident. The Administrator further indicated, all staff, including CNA #2, had attended an inservice on 5/11/11, that included abuse training. On 8/2/11 at 4:45 A.M., CNA #2 was interviewed. She indicated she was so shocked by what she had seen that she			

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	went to get the nurse and did not intervene. On 8/2/11 at 5:45 A.M., the video of the incident was reviewed with the Administrator and one minute and twenty seconds elapsed between the time the CNA first checked Resident #C's room and the nurse entered the room. This Federal tag relates to Complaint Number IN00093942. 3.1-27(b)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review, the facility failed to assure staff intervened immediately to protect a resident who was being mistreated by another resident (Resident #B). This deficiency affected 1 of 1 residents, reviewed for sexual mistreatment, in a sample of 4. (Resident #C) Findings include: During interview on 8/1/11 at 1:45 P.M., the Administrator indicated, on 7/19/11, Resident #B was found in Resident #C's	F0226	1. What corrective action will be accomplished for those residents found to have been afffected by the deficient practice? CNA #2 was educated regarding immediately intervening in possible abuse situations. (Addendum H)2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action was taken? All staff was provided a paper inservice Abuse Refresher on 7/21/11, reminding to staff to stay with the resident, keep them safe, and call for help.	09/01/2011

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	room with his head between her legs. According to the Administrator, hall cameras had recorded Resident #B's entrance into the room at 3:11 A.M. and his removal from the room, at 3:21 A.M. The Administrator indicated Resident #B had no prior sexual behaviors. She indicated, after the incident, Resident #B was placed on 15 minute checks, transferred to a behavior center, and had recently returned to the facility. The Administrator indicated Resident #C was assessed and had no physical injuries. The incident was investigated and reported to the ISDH (Indiana State Department of Health). On 8/1/11 at 2:00 P.M., accompanied by LPN #1, Resident #B was observed in his room in bed. A motion alarm was on the door. During interview at that time, LPN #1 indicated the door alarm was turned on at 10:00 P.M. and would alert staff if Resident #B left his room during the night. The alarm was checked by LPN #1 and was working. On 8/1/11 at 2:30 P.M., the clinical record of resident #B was reviewed and indicated the resident was admitted to the facility on 11/17/10, with diagnoses which included but were not limited to, Alzheimer's disease, dementia and depression.		(Addendum I)3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Policy and procedure was updated to say, stay with resident and keep them safe, call for help. (Addendum J) Policy and Procedure will be inserviced by August 25, 2011.4. How the corrective action will be monitored to ensure the deficient practice will not recur? Administrator or designee will randomly question 5 staff members each month for 6 months about what they would do in an abuse situation with results to QA.5. In compliance by 9/1/11.	

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	The MDS (Minimum Data Set) assessment, dated 5/5/11, indicated the resident had severe cognitive impairment and was independent with transfer and ambulation. The resident was readmitted to the facility from the behavioral unit on 7/28/11. The clinical record of Resident #C was reviewed on 8/1/11 at 2:30 P.M. and indicated the resident was admitted to the facility on 3/1/10 with diagnoses which included but were not limited to Alzheimer's disease and psychosis. The MDS assessment, dated 4/14/11, indicated the resident had severe cognitive impairment and was independent with transfers and ambulation. On 8/1/11 at 3:20 P.M., Resident #C was interviewed. She indicated she had no fear of anyone, and no one had been inappropriate with her. The investigation of the incident was reviewed on 8/1/11 at 3:30 P.M. A statement from CNA #2, dated 7/19/11, indicated she was doing her rounds and heard noises like snoring so she turned on the light in Resident #C's room and saw someone bent over Resident #C. CNA #2 indicated she shut off the light to go get the nurse and then went back to Resident #C's room to double check what she had			

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	seen. "...When I turned on the light I then realized someone was doing a sexual action to (Resident #C's name). I went to get the nurse. (nurses name) I got the nurse & (and) told her someone was sexually attacking (Resident #C's name) & (and) when I turned on the light he didn't stop. The nurse & I went into (Resident #C's name) room & (and) grabbed (Resident #B's name) arm & (and) told him he had to stop & (and) go back to his room..." The statement indicated she had seen Resident #B in the hall earlier and he said he was going to the door to check the weather. LPN #3's statement indicated CNA #2 came and got her and they went to Resident #C's room and found Resident #B's head between Resident #C's legs in her pubic area. Resident #B was "licking or sucking or kissing that area. She was lying there very still..." The statement further indicated, after Resident #B was taken to his room, she the CNA went back to check on Resident #C. "...She said she was okay, grabbed our hands et (and) said 'thank you' several times..." On 8/1/11 at 4:30 P.M., the Administrator was interviewed regarding why the aide had not immediately intervened to protect Resident #C. The Administrator indicated			

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	she had noted the CNA did not intervene immediately and all staff had been inserviced following the incident. The Administrator further indicated, all staff, including CNA #2, had attended an inservice on 5/11/11, that included abuse training. On 8/2/11 at 4:45 A.M., CNA #2 was interviewed. She indicated she was so shocked by what she had seen that she went to get the nurse and did not intervene. On 8/2/11 at 5:45 A.M., the video of the incident was reviewed with the Administrator and one minute and twenty seconds elapsed between the time the CNA first checked Resident #C's room and the nurse entered the room. The policy for "Investigation of Abuse and Protection of the Resident," and the policy for "Abuse Prohibition" revised 5/11/11, was provided by the Administrator and indicated "It shall be the policy...to assure all residents of this facility are free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion... It shall be the policy...to assure the safety of the resident involved during and after any such allegation."			

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	The training material, used during the 5/11/11 inservice, was reviewed on 8/2/11 at 6:00 A.M. and indicated "You are Responsible to Immediately Protect the Resident Should you Witness Abuse/Neglect -You must stay with the resident and call for assistance..." This Federal tag relates to Complaint Number IN00093942. 3.1-28(a)			